DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th — 1/28/17 70th — 2/22/17

PRINTED: 12/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445295	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON MANOR	3641 MEMORIAL BLVD KINGSPORT, TN 37664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual health Recertification survey and complaint investigation #39756 conducted 12/12/16 through 12/14/16 at Holston Manor, no deficiencies were cited in relation to the complaint under 42 CFR PART 483.13, Requirements for Long Term Care Facilities.	F 000		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of	F 166	F 166: 1. Grievance form initiated for resident #224. Items will be found or replaced by 1/18/17. 2. A mailing will go out by 1/18/17 to all residents and/or responsible parties telling them of our grievance policy and where forms can be found. 3. All staff will be trained by risk manager by 1/18/17 on grievance policy and location of forms to file a grievance and what to do with the form once it is filled out. 4. Grievances will be discussed daily in morning meeting by social services. Grievance trends will be brought to QA monthly. POC will be reviewed monthly x 3 months in QA.	1/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

M. L. [illegible] — Administrator — 12/21/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State-Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not	F 166		

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F 166	Continued From page 2 confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, review of the facility's grievance log, and interview, the facility failed to resolve a grievance for 1 resident (#224) of 35 residents reviewed. The findings included: Review of the facility policy Grievances/Complaints, revised 7/18/16, revealed "The facility will assist residents, their representatives (sponsors), other interested family members, or advocates in filing grievances or complaints when such requests are made. The facility will promptly and responsibly investigate grievances or complaints to determine if the facility has areas that need correction to achieve our desire of providing quality care and a safe environment...To ensure any resident, his or her representative...interested family member, or advocate may file a grievance or complaint either	F 166		

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F 166	Continued From page 3 verbally or in writing involving resident care, lost property...The Grievance Official will initiate an investigation into the grievance/complaint. The Grievance Official should communicate with the individual and advise them an investigation has been implemented and follow up should be expected within five (5) days..." Medical record review revealed Resident #224 was admitted to the facility on 8/12/16 with diagnoses including Chronic Kidney Disease, Anemia, and Major Depressive Disorder. Telephone interview with Resident #224's family member on 12/12/16 at 2:00 PM revealed Resident #224 was missing a Bible with her named embossed on the front of the Bible, a blanket, a shirt, 4 pairs of slacks, and a gray fleece sweater. Continued interview revealed Resident #224's family member had told staff members about the missing items. Review of the facility's Grievance Log from 8/1/16 through 12/13/16 revealed no documentation of missing items for Resident #224. Interview with Certified Nursing Assistant (CNA) #2, on 12/13/16 at 10:40 AM, in the hallway revealed Resident #224's daughter had reported missing personal items approximately 2 months ago and CNA #2 had reported the missing items to a nurse. Interview with Licensed Practical Nurse (LPN) #3 on 12/13/16 at 10:50 AM, revealed LPN #3 was unaware of Resident #224's missing personal items. Interview on 12/14/16 at 8:13 AM with the Social	F 166		

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F 166	Continued From page 4 Worker in the conference room, revealed if a resident or family member reported loss of personal property a grievance form was to be completed. Interview with the Social Worker on 12/14/16 at 8:30 AM, in the Social Worker's office, confirmed the facility staff had not filed a grievance form or conducted an investigation related to the resident's missing items and the facility policy was not followed.	F 166		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each	F 278	F 278: 1. Assessment and medical record now reflects that resident #103 has no natural teeth. Appointment has been set to obtain dentures for resident. 2. All residents medical records will be reviewed for consistency of dental status by MDS nurse and Dietary manager by Jan. 18, 2017. 3. Director of Nursing will complete inservice with MDS nurses and Dietary manager by Dec. 30 on physically seeing patient before completing admission assessments. 4. Admission assessments will be reviewed for accuracy by nursing admin for 3 months with results taken to QA.	1/18/17

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F 278	Continued From page 5 assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to maintain an accurate Care Area Trigger (CAT) for 1 resident (#103) of 35 residents reviewed. The findings included: Medical record review revealed Resident #103 was admitted to the facility on 12/24/14 and readmitted on 12/29/15 with diagnoses including Chronic Kidney Disease, Anemia, Diabetes Mellitus, Major Depressive Disorder, Hypertension, and Heart Failure. Medical record review of the significant change of status Minimum Data Set (MDS) dated 1/5/16 revealed the resident had no natural teeth. Medical record review of the CAT, derived from the MDS dated 1/5/16, dated 1/5/16 revealed "...Resident has full set of dentures that fit well..." Medical record review of a Social Progress Note dated 12/12/16 revealed "I spoke with...daughter about an issue the resident has with chewing her food...The residents daughter informed me the resident had dentures prior to coming to the facility however the dog had chewed them up..."	F 278		

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F 278	Continued From page 6 Observation and interview with Resident #103 on 12/13/16 at 9:25 AM, in the resident's room, revealed the resident did not have any teeth, sometimes had difficulty chewing food and would like to have dentures. Interview with the Director of Nursing (DON) on 12/14/16 at 8:45 AM, in the conference room, revealed the resident did not have dentures and confirmed the CAT was not accurate.	F 278		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and	F 315	F 315: 1. The assessment for resident #13 was completed on 12/14/16 by ADON and a plan put in place as indicated. 2. The B&B assessment will be reviewed for accuracy and completeness on all residents by nursing admin by 12/23/16. New plans will be put in place as indicated. 3. All licensed staff will be trained by Dec. 30, 2016 on completing the bowel and bladder assessment upon admission. All new residents assessments will be reviewed at the next weekly clinical at risk meeting. Also quarterly assessments and significant change assessments will be reviewed at the weekly at risk meeting as well by the IDT team.	1/18/17

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F 315	Continued From page 7 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview the facility failed to complete an assessment and develop an individualized toileting plan for 1 resident (#13) of 5 residents reviewed for urinary incontinence of 35 residents reviewed. The findings included: Review of the facility Urinary Continence and Incontinence-Assessment and Management revealed "...4. As part of its assessment, nursing staff will seek and document details related to continence..." Medical record review revealed resident # 13 was readmitted to the facility on 7/5/16, with diagnoses including Diabetes Mellitus and Anxiety Disorder. Medical record review of an admission Minimum Data Set (MDS) dated 8/24/16, revealed resident was always continent of bladder. Continued medical record review of a quarterly MDS dated 11/16/16 revealed resident frequently incontinent of bladder.	F 315	4. Any negative findings will be brought to QA. POC will be reviewed monthly x 3 months in QA..	

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F 315	Continued From page 8 Medical record review of a Bladder Evaluation dated 8/17/16, revealed an incomplete evaluation. Interview with the Director of Nursing (DON) on 12/14/16 at 8:14 AM, in the MDS office, confirmed the resident Bladder Evaluation was incomplete and the resident was not reassessed after having a change of continence.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323	F 323: 1. The restraint found on resident #170 was immediately removed and disposed of by DON. The restraint that the facility uses was put in place. 2. Facility was searched for any other restraints that do not fit our criteria for use by nursing admin and central supply on 12/13/16. No others were found. 3. All licensed staff will be inserviced by risk manager about utilizing the proper restraints by 12/30/16. Nursing documents daily on proper restraint use. 4. Any negative findings will be brought to QA. POC will be reviewed monthly x 3 months in QA.	1/18/17

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F 323	Continued From page 9 by:. Based on medical record review, observation, and interview, the facility failed to ensure a soft belt was applied correctly for 1 resident (#170) of 1 resident reviewed with a restraint of 35 residents reviewed. The findings included: Medical record review revealed Resident #170 was admitted to the facility on 1/31/15 with diagnoses including Nontraumatic Subdural Hemorrhage, Senile Degeneration of the Brain, and Anxiety Disorder. Medical record review of the December 2016, physician's orders revealed "...Soft belt restraint to avoid unassisted ambulation D/T [due to] Senile Dementia check Q [every] 30 min [minutes] release Q [every] 2 hrs [hours] while in chair..." Observation on 12/13/16 at 9:55 AM revealed the resident seated in a wheelchair with a soft belt restraint in place. Continued observation revealed the ties of the soft belt restraint were buckled straight around the back of the wheelchair. Observation with the Director of Nursing (DON) on 12/13/16 at 10:15 AM revealed the ties of the soft belt restraint were buckled straight around the back of the wheelchair. Interview with the Director of Nursing (DON) on 12/13/16 at 10:55 AM, in the DON's office revealed the facility did not stock/order the type of soft belt restraint with a buckle Resident #170 had in place. Continued interview revealed the facility had no manufacturer's instructions for the	F 323		

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F 323	Continued From page 10 application of the soft belt restraint with a buckle currently in use for Resident #170. Continued interview revealed the soft belt restraint was loose and a resident in a wheelchair was not to have a device in place the resident could slide under. Continued interview revealed the resident could have slid under the buckled soft belt restraint and confirmed the soft belt restraint was not applied correctly to Resident #170.	F 323		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data	F 356	F 356: 1. Staffing sheet was corrected when brought to our attention. 2. Scheduler checks the staffing sheet put out by night shift each morning for accuracy. Any inconsistencies will be brought to the attention of the Administrator. 3. RN supervisors will be inserviced by DON by 12/30/16 and given responsibility to complete the form each night. 4. Any negative findings will be brought to QA. POC will be reviewed monthly x 3 months in QA.	1/18/17

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F 356	Continued From page 11 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post accurate staffing data and record the census for 12/12/16. The findings included: Observation of posted staffing data on 12/12/16 at 9:50 AM, revealed staffing was posted as follows: a. Registered Nurses (RN) 4 b. Licensed Practical Nurses (LPN) 9 Continued observation revealed the census for 12/12/16 was not posted. Interview with the Director of Nursing (DON) on 12/12/16 at 10:15 AM, in the DON's office revealed there were 3 RN's and 6 LPN's currently	F 356		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445295	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON MANOR	3641 MEMORIAL BLVD KINGSPORT, TN 37664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 12 currently working and confirmed the staffing data posted was not accurate and did not reflect the current census.	F 356		
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain dental services for 1 (#103) of 1 resident reviewed for dental status of 35 residents reviewed.	F 412	F 412: 1. Appointment has been set up for resident #103 to get dentures. 2. Dental status of all residents will be reviewed by Dietary Manager by 12/30/16 and changes made and outside services obtained as indicated. 3. Each new admission social services will consult with resident and/or family to see if any outside services are needed. Appointments will be scheduled as indicated. New admission charts are brought to our weekly at risk meeting and dental status will be reviewed. 4. Any negative findings will be brought to QA. POC will be reviewed monthly x 3 months in QA.	1/18/17

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F 412	Continued From page 13 The findings included: Medical record review revealed Resident #103 was admitted to the facility on 12/24/14 and readmitted on 12/29/15 with diagnoses including Chronic Kidney Disease, Anemia, Diabetes Mellitus, Major Depressive Disorder, Hypertension, and Heart Failure. Medical record review of the significant change of status Minimum Data Set (MDS) dated 1/5/16 revealed the resident had no natural teeth. Medical record review of the Care Area Trigger (CAT), derived from the MDS dated 1/5/16, dated 1/5/16 revealed "...Resident has full set of dentures that fit well..." Medical record review of a Social Progress Note dated 12/12/16 revealed "I spoke with...daughter about an issue the resident has with chewing her food...The residents daughter informed me the resident had dentures prior to coming to the facility however the dog had chewed them up..." Medical record review revealed no documentation a dental consultation had been obtained. Observation and interview with Resident #103 on 12/13/16 at 9:25 AM, in the resident's room, revealed the resident did not have any teeth, sometimes had difficulty chewing food and would like to have dentures. Interview with Certified Nursing Assistant (CNA) #3 (CNA assigned to care for the resident) on 2/13/16 at 4:00 PM, at the station 2 nursing station, revealed CNA #3 was very familiar with	F 412		

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F 412	Continued From page 14 the resident and had never known the resident to have or wear dentures. Interview with the Director of Nursing (DON) on 12/14/16 at 8:45 AM, in the conference room confirmed the facility had not obtained dental services to meet the resident's dental needs.	F 412		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 514	F 514: 1. Assessment and medical record now reflects that resident #103 has no natural teeth. Appointment has been set to obtain dentures for resident. 2. All residents medical records will be reviewed for consistency of dental status by MDS nurse and Dietary manager by Jan. 18, 2017. 3. Director of Nursing will complete inservice with MDS nurses and Dietary manager by Dec. 30 on physically seeing patient before completing admission assessments. 4. Admission assessments will be reviewed for accuracy by nursing admin for 3 months with results taken to QA.	1/18/17

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F 514	Continued From page 15 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview the facility failed to maintain an accurate medical record for 1 resident (#103) of 35 residents reviewed. The findings included: Medical record review revealed Resident #103 was admitted to the facility on 12/24/14 and readmitted on 12/29/15 with diagnoses including Chronic Kidney Disease, Anemia, Diabetes Mellitus, Major Depressive Disorder, Hypertension, and Heart Failure. Medical record review of an assessment, completed by the dietary department dated 12/23/15 revealed the resident had no chewing difficulty and had dentures. Interview with Resident #103 on 12/13/16 at 9:25 AM, in the resident's room, revealed the resident did not have any teeth, sometimes had difficulty chewing food and would like to have dentures. Interview with the Director of Nursing (DON) on 12/14/16 at 8:45 AM, in the conference room confirmed the resident had not had dentures since admission to the facility. Interview with the Certified Dietary Manager (CDM) on 12/14/16 at 10:10 AM, in the conference room, confirmed the CDM had	F 514		

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HOLSTON MANOR	3841 MEMORIAL BLVD KINGSPORT, TN 37664

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F 514	Continued From page 16 completed the assessment form dated 12/23/16 indicating the resident had dentures. Continued interview confirmed the resident did not have dentures and the medical record was not accurate.	F 514		